Overview: Two Campus Experiences

UCSF

- Moved to EPIC in 2012
- Outpatient clinics phase in began Spring 2012
- "Big Bang" June 2012
  - Inpatient and ED services
  - Hospital and pro fee billing
  - Certain legacy systems remain (lab and rad)
- Fall 2012 began electronic EHR exchanges with other institutions (CareEverywhere)

UCLA

- Various electronic systems currently
- Moving to EPIC in Spring 2013
- All hospitals, about 20% of clinics
- Remaining clinics phased in for 18 month period

New Age Freedom?

- Benefits of EMR are numerous:
  - Legibility
  - Single source can be used by multiple individuals at one time
  - Available across the continuum of care
  - Information available to patients quickly in portals and electronic formats
  - Reduce costs if tests available and reduce need to retest because results are not available
  - Data easily available for quality, performance improvement, research
  - Solves a number of old problems

or New Age ePATH Compliance Risks?

- Security Settings
- Documentation to Support Reimbursement
- Scope of Practice
- Signature Issues
- Meaningful Use
- Transition from Paper to Electronic World

Pre and Post Go-Live

- Before Go Live and as documentation is being developed, decisions need to be made about security settings, roles, scope of practice.
- How the workflow will change. The paper workflow does not always translate well to the new environment
- Testing and validation are Key. Testing often done in testing environments. Need to validate the entire process and how information flows downstream
- What is process of reviewing changes to the EMR after go live?

Security Settings

- How do you balance the desire to have narrow security roles versus the difficulty to manage numerous roles?
- How do you assure security settings are linked to the right scope of practice for the individual?
- How do you handle confidentiality issues for
  - Persons of Interest
  - Behavioral Health locations
  - Substance Abuse
  - HIV Clinics

Documentation Considerations

- Use of Efficiency Tools
  - Copy Paste (cloned documentation)
  - Auto-fill
  - Normal/negative Templates
  - Documentation errors and discrepancies
  - Compliance Auditing Focus
    - Quality
    - Unsigned Notes
    - Cloned documentation
    - ABN/Medical Necessity
    - Policy?

Translating from paper to electronic

- Handling records that are put in to the paper record by multiple parties but cannot be recorded in the EMR as one OR
- Multiple contributors to one note: how do you identify who documented which portion of the note?
- You might identify activities that are non-compliant in the paper world that you do not want translated to the electronic world (for example scope of practice of medical assistants, what is the process for refilling prescriptions?)
- Audit trails and time stamps on records provide new tools to validate when information added but it can expose information that is "pre-filled"
  - Example: Discharge note started at time of admission to capture events as they occur. On admission, note shows "patient discharged in good condition".

Regulatory Environment

- CMS is paying out significant amounts for Meaningful Use Incentives
- CMS is also looking at increase in E/M levels in EMRs
- CMS and OIG are watching EMR Documentation (OIG Workplan 2013)
- September 24, 2012 CMS and DOJ issued a warning letter to five healthcare associations regarding the use of EMRs to bill for higher levels of services than what was performed
- Recovery Audit Contractor Impact

Template Preparation

- Do you allow
  - Pre-populated normal findings?
  - Functions that make me the author or change author on edit?
  - Scribes?
  - Does the audit trail show who documented what portion of the note?
  - Does the document show if any items were copied from another note?

Template Guidance CMS

- CMS issued Transmittal 438 on 11/9/2012
- Does not prohibit use of Templates but discourages use of templates that provide limited options and/or spaces for the collection of information such as by using check boxes, preferred answers, limited space to enter information.
- CMS review of claims identified that these types of templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

AMC Challenges

- Does the record reflect the contribution of the medical student, resident, fellow and attending?
- Attending can bill for “linked” note but limitations on what elements of note can be used for billing (based on who documented it).
- Who documented the chief complaint or the HPI?
- Can you tell who created which parts of the note?
  - Was it the medical student or the resident?
  - Can you tell who authored the teaching physician statement without looking at corrections history on document or the audit log?
  - Is the only documentation by the attending the TP statement?

Teaching Physician Statements

- Are you using only one?
- Who is adding it to the note?
- Can it be edited or customized to the patient?
- Different for beside procedures?
- Diagnostic Statements ie ultrasounds in clinic?
- Primary care exception

AMC Considerations

- How are you handling Mid-level providers?
- How are you documenting a shared visit?
- If the NP/PA sees the patient without an attending, are you requiring a signature by the attending?
- How are you using the documentation from ancillary staff: Medical Assistants, nurses, pharmacists?

Scribes

How are you handling scribes?

- Who can scribe? Does the scribe have a dual role?
- Documentation in record: is it clear what information was scribed?
- Can you capture signature of scribe and physician?
- Do you allow medical students to scribe?
- Teaching Physician situations

Hospital Based?

- How are you handling facility documentation?
- Using the physician documentation alone?
- A separate nurse or medical assistant note?
- Nurse only visit?
- Is any part of their note auto-populating into the physician note? How do you know?

Signature Issues

- Who can sign a document?
- What is the audit trail for the signatures
- How do you demonstrate who signed what?

Quality of Documentation

- Patient in Emergency Department for eye contusion. Record shows that patient had a trans abdominal ultrasound performed.
- Does the record support tests performed?
- Is there a missing link in the documentation?

Diagnosis

- Who's entering the diagnosis?
- Does the system allow the MD to pull in all of the health issues the patient has into the note?
- How do you ensure the diagnosis are relevant to the visit?

Orders and other issues

- Who can transmit prescriptions?
- Do you allow anyone to write it for physician signature?
- Can orders be carried out before MD Order is placed?
- Do you use order protocols? How are they documented?
- Does the order have a reason for the test or a diagnosis code?

Other Considerations

- Are you using exploding templates?
- How does your physician pull in lab test results, medications into the note? Everything?
- If using natural language processing to record information, is the physician checking to make sure that the information is correct?
- ICD-10: Are you considering Computer Assisted Coding from your EMR?
- How do you manage changes in the EMR configuration after go-live?

Manage the Risk

- So, how do you mitigate these risks?
  - Be at the table especially if the physician champions for the EMR are not the ones with expertise on the teaching physician rules
  - Educate physicians
  - Develop policies
  - Re-evaluate audit strategy: provide feedback to physicians as quickly as possible
  - Review test documents
  - Audit behind the implementation: the MD will find ways to document that IT Team did not test
  - Validation process

How do you audit the EMR?

- Change your audit tools?
- Validation tool?
- Are you checking the document corrections to make sure no prefills?
- Cloned notes from visit to visit are obvious.   How does this change your auditing process?
- Tools to find differences in notes
- Auditing real time?
- Are you looking at time/date of entries. Is the eprescribing code used for a prescription during the session. What does the record show?

Meaningful Use

- Have you set up your EMR so that you are capturing the data elements for Meaningful Use?
- Is there anything you are setting up that will impact Meaningful Use?
- Have you prepared or conducted the necessary privacy and security risk assessment?
- How will you document the items that will be audited once you attest to Meaningful Use?

References

- AAMC Guidances
- Sebillius Letter
- TP rules